

**ASSIGNMENT OF PROCEEDS AND/OR LIEN FOR MEDICAL SERVICES
HIPAA AUTHORIZATION**

Patient Name: _____ **Attorney Name:** _____

DOB: _____ **Phone Number:** _____ **Attorney Phone:** _____

Date of Injury: _____

I hereby authorize and direct my attorney, to pay directly to New South Medical ("NSM"), such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from my settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you, my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I acknowledge that I may also be responsible for any applicable charges, fees, or costs associated with the services rendered.

Additionally, I understand that, in accordance with the Health Information Portability and Privacy Act of 1996 (HIPAA), my medical information may be shared in order to manage and expedite my medical care. I authorize **NEW SOUTH MEDICAL** and its affiliated medical providers to secure, release and disclose such medical information as provided herein. My signature is an acknowledgement that I have received a copy of this authorization assignment.

Signature of Patient Signature of Parent/Guardian

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY
To be Completed by your Attorney:

The undersigned Attorney of Record for the above-named Patient, hereby agrees to acknowledge all terms stated herein and agrees to withhold such sum payable to New South Medical from any settlement, judgment or verdict as may be necessary to adequately protect New South Medical. The Attorney is expressly instructed to hold in the Attorney's Client Trust Account such sums from any payment, settlements, dispositions, proceeds and/or verdicts received on Patient's behalf as may be required to adequately protect and pay NSM for services rendered on Patients behalf by NSM. The Attorney is further instructed to pay from the Attorney's Client Trust Account to NSM that amount which is due and owing to NSM for those medical services, examinations, treatments and reports which NSM has prepared on Patient's behalf. Attorney further agrees that in the event Patient secures other counsel in connection with any action instituted by Patient on account of the injuries for which Patient was treated, Attorney shall inform such new counsel of the Agreement, and secure new counsel's consent there to. Failure of Plaintiff Attorney to sign and return this document to NSM does not release him/her of the fiduciary responsibility of ensuring that the above Patient's outstanding medical bill for treatment rendered for injuries sustained on the above captioned date is paid unto NSM out of the proceeds of his/her case per your client's written request.

Attorney's Signature: _____ **Date:** _____

*NOTE TO ATTORNEY: PLEASE SIGN AND RETURN ONE COPY OF THIS DOCUMENT TO **NEW SOUTH MEDICAL** AND KEEP A COPY FOR YOUR RECORDS.